




Catastrophe Mental Health

Emergency Planning, Mental Health & Catastrophic Events; Policy & Practice Implications

The Northern Ireland Centre
for Trauma & Transformation

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Emergency Planning, Mental Health & Catastrophic Events: Policy & Practice Implications

Based on the deliberations of the Joint UK – USA Workshop held at the Emergency Planning College North Yorkshire, England 12 – 15 September 2005

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Preface

This Report has been prepared from the discussions that took place at a Workshop held in the Emergency Planning College, Easingwold, North Yorkshire, England from the 12-15th September 2005. A lot of ground was covered in two and a half days, and the participants all contributed in providing presentations or in the discussion groups.

In writing the Report the principle aim has been to distil the key policy and practice issues, which the workshop explicitly identified as important or which emerged through the discussions. Where known and clearly identifiable, all third party material has been referenced either to the original source or the contributor. Where such material is used without acknowledgment and or reference, it has been used in good faith and when such oversight is drawn to our attention, the references can be corrected in subsequent versions of this Report or its derivatives.

David Bolton
Report compiler
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Overall aims of the workshop

1. To explore the current knowledge base on the psychological and mental health risks associated with major traumatic events such as terrorist attacks, natural disasters or other cataclysmic disasters.

2. To identify the implications for clinicians, planners, policy makers, agencies and governments.

3. To consider the implications of major traumatic events for community stability and cohesion.

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Pictures on front cover top to bottom and left to right:
(1) Street night scene New York; (2) Street scene Sri Lanka; (3) House damaged by bullet holes, Sarajevo; (4) Tram in a rebuilt Sarajevo; (5) Beach fishing Sri Lanka; (6); View from Pokhara, Nepal of Annapurna range; (7) Woodcut of London's inhabitants fleeing the plague epidemic in London 1665; contemporary woodcut with later colouring; AKG-Images; London

Introduction

Michael Charlton-Weedy CBE
Chief Executive
United Kingdom Cabinet Office Emergency Planning College
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The mental health consequences of disasters are the hidden dimension of emergency planning and management. The public fixation with the high-impact visual images that present the immediate violent impact and drama of disaster – casualties, blood, flame, smoke – can blind us to the insidious, far-reaching and enduring psychiatric consequences for the few that are directly involved and the many that observe or are linked in some other way to the event. While we might manage the incident in hours, the consequences mitigating in days and weeks, and the physical recovery in years, the mental health consequences will endure for decades. They will be real and present for those that suffer and those that treat them, long after the disaster has become the matter of history.

These consequences are both individual and collective. The management of individual trauma is a domain shared by families, communities and practitioners. Emergency planners and managers must take full account of the needs arising from traumatic experiences. In contrast, collective trauma will directly impact both the response and recovery phases. Indeed it may form a major recovery objective in its own right, and may even be the critical path to a totally recovered state. It is therefore essential that emergency planners and all leaders who have responsibilities for the management of disasters understand the importance of mental health issues in every stage of their operations and act accordingly. This workshop was an invaluable first step towards that aim, and accordingly I commend its proceedings to you.

MCW

1.0 Background

The Workshop took place at the Emergency Planning College near York, England on the 12-15th September 2005. The idea for the Workshop arose from the relationship that had developed in the wake of the 9/11 tragedies in New York, between the staff care units of the City's Police and Fire Departments and the Port Authority, and the Northern Ireland Centre for Trauma & Transformation. The British Consulate in New York had been very supportive of the connection between the Northern Ireland Centre and New York, and secured funding to partly sponsor the Workshop.

The focus of the Workshop was the mental health implications of major catastrophic events. This theme was identified as it was considered to be an aspect of disaster planning that required further thinking and development. On one hand the developing knowledge and experience of managing relatively smaller scale disasters was a resource to be drawn upon and applied to even larger scale tragedies. On the other, current world threats and specifically the possibilities of large-scale terrorist related events, was making it increasingly imperative that the mental health aspects of such events should be planned for.

As a joint UK-USA event, the delegates were drawn more or less 50:50 from both countries. Ironically, at the last minute the disaster caused by Hurricane Katrina, which struck New Orleans and the Gulf of Mexico coastline on 29th August, led to a number of the American delegates dropping out at the last minute, although one new delegate was able to join us because of the relevance of the programme to the tragedy. This event and its consequences brought immediacy to our considerations, as did the events of 7th and 21st July earlier in the year in London when bombs exploded (or were set to explode) on the London Underground and bus transport systems.

Funding and accommodation restrictions limited the number of delegates who could be invited, so an effort was made to bring together as wide a representation of disciplines and experiences as possible. The Programme Coordination Team was very happy that such a mix was achieved and was more than satisfied with the quality and breadth of the discussions and the contributions from the delegates who contributed. Further, we saw the Workshop as contributing to a wider discussion on the theme of 'catastrophe mental health' and that opportunities for developing its achievements would arise in the future. To that end the Workshop explicitly identified areas for further consideration and research.

The Workshop focussed heavily on the significance of disasters and catastrophes for western, industrialised and developed communities and nations influenced by the national identities, the experience and the work of the participants, and the Workshop's remit. We acknowledge the limitations of the Report for other more agrarian and less developed contexts, although would draw attention to the potential of the Report's conclusions to inform disaster preparedness and responses in such circumstances. The Report draws attentions to the necessity of considering resource and cultural

considerations in responding in to disasters and catastrophes. We would add that in relation to mental health and wellbeing, in relation to psychological functioning, and in relation to things to do with meaning and value, seeing each person as a human being with whom we all share common concerns for self, family and community can carry us a long way in planning for, and responding to, tragedy, and ultimately in caring for those affected by such events.

It was always envisaged that a Report of the Workshop would be produced as a concrete output. The debate as to whether it should be long and detailed or brief and to the point, was readily resolved; a short report that people would read was agreed upon. As a consequence the full detail and value of each contribution will not be recorded. In view of this it is singularly important to acknowledge the contribution of the delegates, their willingness to participate and engage with the task, their interest in the subject and their collective wisdom derived from experience, research, study and planning.

We also acknowledge with warm appreciation the support of the New York Consulate in New York, along with the British Embassy in Washington and the practical support and experience of the Emergency Planning College and the Chief Executive Michael Charleton-Weedy, in accommodating the delegates and facilitating the Workshop.

Leslie Slocum, The British Consulate-General, New York
Julia Fogarty, The Emergency Planning College
David Bolton, The Northern Ireland Centre for Trauma & Transformation

Programme Co-ordination Team

January 2008

2.0 The challenges of catastrophic events

In his introduction to the 1969 edition of Defoe's book; *A Journal of the Plague Year* Louis A Landa, Professor Emeritus of English at Princeton University, reflects on the author's description of the unfolding tragedy of the plague of London in haunting terms. He says,

> "*People die by the thousands, families and parishes are decimated, physicians, clergymen, tradesmen, the rich and the poor are carted off to graves; but these are nameless dead and the tragedies, with few exceptions, are not individual. The tragedy is corporate. It applies less to this or that person or family, more to the greater organism, the stricken city ravished by plague, its people either fled or dying, its marts closed, its vast energies replaced by silence and inaction.*"

This evocative overview, reveals an utterly shocking state of affairs; the thousands of deaths, the devastating and indiscriminate nature of the plague. It also captures the emotional, psychological and spiritual struggle to ponder the implications of tragedy on such a scale, and of how we lose the capacity to comprehend what is happening in individual terms but rather see the tragedy as 'corporate', as the death of a city rather than of thousands of individuals. The observation also conveys the feeling of how, as the city dies, like an engine that is running down; its life and energies are dissipated, the victims of plague and those without resources abandoned by those who hold office and families; its people gone.

In beginning to wrestle with the task that needs to be undertaken to address the implication of such events, we as policy makers, planners and service providers need to peer over the edge of such terrible possibilities to begin to get a sense of the scale and the challenge, and also to begin to confront the emotional impact such a situation would have on those who ultimately would be responsible for the recovery of such circumstances. How on earth do we get to grips with such a prospect? How can we respond? Where do we begin?

Yet respond and begin we must. The necessity and the impulse to address and overcome tragedy, even on such a scale, go to core of our humanity. It is not alone about the survival of the species or the easing of suffering, it is about practicing and retaining that vital spark which stands between us and utter depravity, that holds us together in community and which inspires and enables us to reach for the stars.

2.1 The nature of the threat

The threats that face us include those posed by natural processes of illness or natural environmental or geological disasters. The threat from groups of

terrorists or others acting against civilian populations with indiscriminate and deadly agents defines another area of risk. The latter arises in good part as a result of the possibility of manufacturing or accessing highly destructive and deadly materials.

Whilst technological and built-environmental sophistication, along with personal and societal wealth, offer a relative bulwark against such events, they can be the Achilles heel, when for example, the widespread and enduring loss of communications or power, or the inundation of extensive areas can render technology useless or make redundant and unusable areas normally inhabited by human populations, or used for important and essential infrastructure. Another risk comes from the danger of deadly disease impacting upon those who serve the community and the loss or incapacity of such citizens will pose another threat. Further, the highly developed skills in using technology and in manoeuvring around the built and social environment can be seriously challenged in the face of such circumstances, with the absence of skills and knowledge on how to survive and function in less advanced circumstances being a concomitant source of vulnerability. Again, the fear and the breakdown of bonds and trust, which can result from these events, especially those caused by human intent, or from events which unfold over a period of time with no certainty on the how or in which direction they will unfold, can create very unstable conditions. Surviving will depend upon a combination of the level of preparedness, the capacity to adapt and of 'luck'. In summary then the key factors that contribute to vulnerability include:

1. Threats from: -
   a. Naturally occurring deadly disease
   b. Environmental or geological events
   c. Transportation and other technological disasters
   d. Conflict, war and terrorist groups
2. The consequent loss of essential facilities and skilled public servants
3. The ineffectiveness of pre-existing (and no longer as relevant) survival and social skills and knowledge in a dramatically different and challenging environment
4. The absence of knowledge and skills on how to cope and survive in a dramatically different environment
5. The consequences for and loss of social and community bonds and trust
6. The capacity to adapt.

In mental health terms the most significant consideration is that whilst the threat might be to the community as an entity, it is still the individual characteristics and the specific interaction between the individual and the trauma that will largely shape who is affected.

In this report much use will be made of the word 'community'. For the purposes of disaster planning can we define the term in precise terms? In the context of this report the implication is that, generally, we are discussing the impact of major disastrous events on geographically

definable populations for which the word 'community' is used as shorthand. It might be useful and relevant for planners and service commissioners and providers to regard a population as 'the community', but this might not be how people living in that locality see themselves. Experience tells us that within a population there may be many ways in which we could use the term. One's next-door neighbours might not be as important in one's life as someone with whom one shares a significant common interest, yet who lives far away. However, following a disaster, one's neighbours might assume much greater importance. Where a disaster impacts upon a dispersed and transient population, for example in transportation disasters, then those directly involved and affected will probably have only passing connection with the locality (the community) within which a disaster occurs. In practice, we might expect in such circumstances for there to be both a local and dispersed group of people affected by the disaster. The impact of the death and disability of parents and adult carers for children, adolescents and other vulnerable citizens is clearly a major consideration for a community.

In the Workshop, Gerry Jacobs defined community as '*people who share common interests*'. In disasters this is a very fluid term in that it is possible and likely that one might relate to a different constellation of people before and after a disaster. Following a disaster, as well as the desire to connect with one's pre-disaster community, one may need to rely upon or support others whom the disaster has brought into one's life and circumstances. Survival may depend upon it. So, in a sense planners have to work with what is in place, acknowledging and working with pre-disaster communities whether population based or self defined, mindful too of the emergence of post disaster, and perhaps temporary communities. Ultimately beyond the disaster, in very devastating circumstances, a challenge exists for creating a new functioning community. To summarise, a number of questions arise regarding what is meant by 'community' and they include:

- Is it possible to recognise a community identified in location and service terms?
- Is there one or more identifiable leaderships associated with the affected population?
- Are there clearly definable political and administrative entities through which the local population is provided with amenities and services?
- Are there distinctive groups within the affected population that have their own cultural ethos or other identity and leadership?
- Has the disaster thrown up new, perhaps temporary, communities and leaders with whom service providers etc. can relate?

Martin Buber's thoughts on the challenge of re-establishing a community seem highly relevant here:

> "*Community should not be made into a principle; it, too, should always satisfy a situation rather than an abstraction. The*

realisation of community, like the realisation of any idea, cannot occur once and for all time; always it must be the moment's answer to the moment's question, and nothing more[1]."

This suggests that the goal is not to reinstate that which existed prior to a disaster (in any case an impossible task) but to build a new community which incorporates as much as possible of the past that is positive, builds upon what people have learned from the disaster (again focusing on strengths and growth) and addresses the needs and aspirations of the new emerging community; in other words, *the moment's answer*.

2.2 Assessing the scale and the seriousness of catastrophic events

Central to this workshop were the questions:

1. Are catastrophic events different in terms of mental health risks and outcomes than less large-scale disasters?

2. What are the specific challenges in planning for and addressing the mental health consequences of catastrophic events?

The answer to these questions will depend clearly upon each case. However in general terms we might assume that the impact on mental health of catastrophic events will depend to one degree or another upon the extent to which each of the following factors apply:

1. The degree of pre-catastrophe preparedness

2. The capacity of the community infrastructure and resources to sustain the impact of the catastrophic event

3. The resilience or vulnerability of community infrastructure (including power, communications, and transport)

4. The population has had time to plan ahead of a specific catastrophic event (or events)

5. The population has had time and the facility to get (and remain) out of immediate harm's way

6. The scale of personal loss including:

    a. Loss of emotionally close persons – family, colleagues, friends, neighbours)

[1] Buber; "In the Midst of Crisis" in Twentieth Century Political Theory: A Reader By Stephen Eric Bronner; p.126; Routledge 2005

b. The degree of multiple loss

c. Injury

d. Loss of homes and other important or valued property (schools, places of worship, places of work, civic property, other shelter)

e. Impact on personal economics and loss of income

7. The degree (intensity and duration) of subjective experience of menace, threat, near death experiences etc.

8. Whether the index event is followed by additional or consequential traumatic experiences

9. The quality and duration of temporary accommodation

10. The level of displacement (relocation) and separation

11. The degree to which the threat or uncertainty endures (especially relevant in CBRN incidents)

12. The capacity, willingness and competence of international, central and community governance systems, and leadership

13. Whether the catastrophe accentuates pre-existing tensions or fissures in social relationships, or whether such are taken (mis)advantage of by one interest or another

14. The capacity and speed of public rescue, medical, health and support services

15. The degree and speed at which lost homes and communities can be reoccupied and normal or acceptable life conditions resumed.

2.3 Why mental health is important

We now know a great deal about the adverse effects of psychologically traumatic events on individuals. Likewise, knowledge about when and how to intervene, and to do so effectively with psycho-educational and clinical services, has developed to a point where we can, with considerable confidence, plan for and determine what needs to be done before, during and after a major traumatic event. Previously, when our knowledge was less developed, it was not clear what the needs would be, or how best to intervene following major incidents and it was therefore not surprising that planning failed to adequately include mental health responses.

Apart from the fact that we better understand the mental health risks etc. and how best to respond there are a set of linked arguments which support the

development of an effective mental health response to major incidents, and in the context of this document, to catastrophic incidents.

These can be summarised as follows:

1. Trauma related disorders represent a significant public health issue

It is well established that traumatic events can lead to the development of a range of psychological and mental health disorders. Besides post traumatic stress disorder (PTSD), persons affected adversely can suffer depression, one or more anxiety disorders (such as specific phobias, or panic disorder)[i] Exposure to repeated or chronic traumas can contribute to the development of personality disorders and other chronic and complex disorders. Gauging the levels of PTSD can assist us in obtaining an understanding of the levels of ill health that can follow exposure by communities or large groups of people to traumatic events,

- Epidemiological studies suggest that between 30% and 60% of people directly exposed to traumatic events associated with human-made or technological disasters will develop post traumatic stress disorder (PTSD). (From studies, the range for rescue workers is found to be between 5-40% and for the general population 1-11 %.)[ii] These findings are from a meta analysis and this partly explains the ranges and variation. The data from environmental and natural disasters indicates lower outcomes although this needs to be seen in the context of the difficulties in accessing and assessing affected populations, after say, a hurricane.
- Studies of recovery from PTSD suggest that whilst over 40% will recover within 12-30 months, between 15% and 35% will have PTSD in the long term (and perhaps, for the remainder of their lives)[iii] [iv].
- Besides PTSD, trauma related depression and other disorders can arise in direct response to traumatic experiences, so the measure of PTSD does not give us the full picture of the level of illness that arises after exposure[v].
- People with long term and chronic trauma related disorders often present with one or more additional mental health disorders that have arisen in consequence of the original traumatic disorder.

There are important reasons for focusing on PTSD as, by definition, this condition only occurs in response to traumatic experiences. The condition is very distressing for sufferers and has considerable implications for functioning, relationships and engagement in social and economic activities. Acting like a trace dye, knowledge about the level PTSD related need is a very sound indicator or barometer of the human consequences of disasters. Such knowledge can inform policy and practice.

2. Mental illness can adversely impact on the ability of the person to function, on their relationships, and on the ability to contribute effectively to social and economic life.

The fact that a proportion of the community will be adversely affected by a traumatic event poses a significant issue for emergency planners and service providers. The wellbeing of citizens, including those who will be relied upon to respond to a disaster, ought to be a key consideration in the context of a major disaster, where the community faces major challenges in relation to stability, adjustment and recovery, and social and economic functioning (whilst trying to maintain conventional community services).

3. The issue of mental health is one component of several that require attention after disasters to promote community stability and adjustment.

The focus here is not on mental health *services* per se, but on the task of minimising the onset of mental ill health and promoting recovery and adjustment. There needs to be a focus on mental health issues therefore in the wake of disasters as one of the key elements of the effort to restore community wellbeing and functioning by which we mean social cohesion, solidarity, economic activity:

Other key elements include: -

- Clear leadership aimed at serving the greater good and the well being of as many citizens as possible
- Maintenance of law and order
- Restoration of essential services and food supplies
- Restoration or adequate replacement of housing and other basic facilities
- Promotion of collective responsibility for the task of recovery.

4. The long-term invisible mental health impact of disasters.

The Workshop participants drew attention to the invisible mental health impacts of exposure to traumatic events. This is due to a number of reasons, for example;

- Reluctance to seek help linked to feelings of stigma about mental ill health
- Difficulties in recognising one's inner distress as normal or capable of being successfully addressed, leading to withdrawal and 'putting on a brave face'
- Reluctance of those not so centrally involved but nonetheless seriously affected to see themselves as being legitimate seekers of help or subverting their own needs in the belief that others have more obvious needs and entitlement to help

- Fear of seeking help, amplified in times of danger or threat where making oneself visible would increase one's feelings of being in danger or actually increase such a risk
- Difficulties in seeking help due to a loss of trust, which may be an artefact of the traumatic reaction or in times of conflict concern about making oneself visible as described in the previous point
- Children will take their cues from important adults and might be reluctant to express their concerns for fear of the reactions this might stimulate in adults, or because children withdraw when adults minimise the legitimacy and reality of reactions or of seeking help
- Some people might not link their distress and difficulties to the traumatic events.

The important point here is that some adults and children with needs will not be identified until some time has passed. Some may never in fact be identified or identify themselves as having been affected by their experiences. Examples were shared at the Workshop of people seeking help decades after being involved in traumatic events. This all points to specific services being available beyond the short term into the middle term response, and ultimately, the need to build capacity in mainstream services to identify and respond appropriately to trauma related needs and disorders in the longer term.

2.4 How attention to mental health needs contributes to the goal of community restoration

In disasters many people might have been exposed to traumatic experiences or have lost relatives, friends or colleagues, or suffered other important losses (e.g. housing, neighbourhood, socially or culturally important features of their personal landscapes). As a consequence a section of those who are exposed will go on to experience a short term period of emotional and psychological distress and those who do not recover from this short term effect (along with others who develop problems later) will develop more serious mental health and psychological problems. These needs are arising at a time of uncertainty, worry and instability.

Efforts to promote mental health and wellbeing can help to:

- Provide a sense of direction to the task of restoration – through a sense that recovery is possible over time and by imparting a sense of hope and the expectation of recovery
- Promote coping (including the ability to live with a level of distress), insight and awareness of personal reactions and those of important others, and the ability to judge when best to seek help
- Promote the capacity to understand others' distress and needs, and how these will change over time.

3.0 Approaching the task of addressing mental health needs after disaster

3.1 A Disaster Mental Health Strategy; Key considerations

A clear and strong message from the Workshop was the necessity of the integration of a disaster mental health response into the wider governmental, administrative and social plans for the recovery of a community following a disaster. This was seen to be particular important in catastrophic events, where community restoration, stability and continuity are contingent upon a number of dimensions, including a disaster mental health response. Disaster mental health must be a key component in establishing and maintaining community sustainability in the face of breakdown, challenges to law and order and the redrawing of power relationships.

The social and economic costs and civic implications of post disaster distress and mental ill health, and of the duty of care considerations, are important and unavoidable arguments for addressing mental health at the highest levels of disaster planning. Additionally, disasters have an impact on the disaster workers and helpers also, and if we are to maintain a capacity to mount a disaster response then the support and care of disaster response and essential services staff is a vital component of planning and action. These realties draw attention to the need to invest meaningfully in disaster mental health planning and services. Such investment should be viewed in costs benefit analysis terms, in the context of the costs of disasters to individuals, to the community, to organisations, to public bodies, business, insurance companies and the economy.

Workshop participants shared a concern that there is no serious consideration of the mental health implications and response and service requirements in relation to disaster planning. It was concluded that the commitment to a mental health response is required at National levels to support planning and to ensure this dimension of response is incorporated into plans and ultimately into action. As well as a national strategy, local political and administrative structures responsible for disaster responses should have appropriate versions of disaster mental health strategies, replicated in turn at more local and organisational levels where appropriate. National and more local strategies and plans need to pay attention to the delivery of mental health services and responses in the context of terrorist related disasters, especially where there are perceived or actual community tensions, and where as a result there is an on-going sense of anticipation and fear of further incidents or reprisals.

Recognising that different governmental arrangements pertain in the UK and the USA, the Workshop agreed that further consideration is required as to how best to develop further and incorporate current mental health advice into

planning, early response and recovery stages of disaster preparedness. This is an important challenge as participants considered that mental health within health and social care and across the public sector is not given sufficient weight nor is the contribution of mental health in social and economic terms adequately capitalised upon. Further, there is still considerable stigma associated with mental ill health, which is an obstacle for users and potential users in a post disaster context. This difficulty may become an obstacle for planners as they struggle with how to address a socially value laden subject.

By bridging research into practice and through service design, the role of service commissioners (chiefly public sector, but also including insurance organisations) was considered by Workshop participants to be a vital ingredient in securing evidence based, effectively and efficiently deployed, and accessible services.

Some of these matters are address further below.

A corollary of the need to address mental health issues in disaster planning at the highest levels is the necessity of mental health services themselves (including in this instance planners, commissioners, providers and trainers) in planning for mental health responses in the wake of disasters to recognise that conventional pre-disaster service arrangements will most likely be insufficient to address anything more than a very small scale, localised major incident. This then requires specific responses tied to the configuration of services after a disaster, and the design and development of evidence based, relevant and sensitive services. In considering this important dimension, the Workshop participants had concerns as to whether our service structures and institutions have the capacity to respond to and manage the mental health implications of disasters and associated risk issues. Further, given the traditionally perceived 'second division' role of mental health in the mainstream of health and social care, do we have the leadership within mental health services to handle and respond to the challenges of disasters? This was considered to be an important area to pursue.

It was agreed that services developed and operating in a pre-disaster (or non-conflict) context would not be capable of providing an effective post disaster mental health service unless there was substantial preparation and a considerable reorientation of services in the wake of a tragedy or conflict. This is a critical point as reliance upon conventional services, skills, knowledge and systems would not enable appropriate access by the public to services. Further, the public would be expecting a relevant immediate post disaster service. Where unexpected expectations come up against an unprepared and unskilled service, the public become disillusioned, organisations become redundant and face criticism of their role and practitioners become deskilled.

3.2 Taking a strategy forward

The Workshop concluded that at national, state/regional and more local levels representatives of mental health charged with the task of planning for disaster mental health responses should be 'at the table' in terms of: -

1. Planning phases
    a. To ensure plans incorporate mental health concerns, issues etc.
    b. To enable other organisations' and sector plans to accommodate and take account of mental health considerations
    c. That 'good rescuing' would be mindful of mental health throughout early phases
    d. To support other (non-mental health) emergency services in providing support for their own staff
2. Early response phases
3. Recovery phases.

Disaster mental health networks, bringing together key organisations and sectors to focus on the planning and delivery of services, could underpin this planning work. Workshop participants thought that this is ideally done in the first instance at a local level, recognising that at times of overwhelming and highly destructive disasters, external help and responses will be required. Local planning should be set within higher levels of planning at regional and national levels. Local plans should be informed, shaped and supported by National and State (USA) and National and Regional (UK) planning arrangements.

Local planning and response arrangements should be able to advise higher levels as to what is needed, and what can and cannot be provided locally. This should include the coordination of local statutory, voluntary and other community service and capacity. Local planning and responses should build upon local strengths and resources, maximise coping and be mindful of local issues and sensitivities.

The mental health dimension of the task of post catastrophe recovery needs to be viewed as being wider than a clinical function, although there should be clear evidence-based leadership and direction from services and practitioners competent in trauma related needs and services. This aspect of community recovery needs to be seen as much as possible as a collective responsibility, involving as many as possible. Community leadership should incorporate key principles and messages in its actions and responses to support recovery and adjustment.

Responses need to include efforts to promote solidarity, reduce isolation and to address areas of pre-disposing and consequential vulnerability e.g. financial problems, housing, employment, education, care for vulnerable family members. Psychologically, particularly in the early stages, efforts should be made to enable and support the individual in correcting the traumatic psychological appraisals created by their experiences and loss, and to supporting grieving by individuals and communities. Ceremonial and

ritualistic responses, that are timely and congruent with the experience and culture of those affected by the tragedy, can also be very helpful in that regard.

As noted already at the beginning of this Section, key to taking these observations forward is the development of a Disaster Mental Health Strategy at the appropriate political and administrative levels.

The considerations of the Workshop and this Report enumerate what are effectively key features of such a Strategy in some detail and are summarised as follows:

A Disaster Mental Health Strategy should have the following characteristics.

- ⊕ Have a common core and clear evidence-based outcome goals
- ⊕ Be adapted to the uniqueness of each affected community
- ⊕ Be culturally appropriate and sensitive
- ⊕ Should plan for sufficient resources should be made available for an appropriate range of services at an acceptable cost
- ⊕ Have a meaningful commitment to evaluation
- ⊕ Be clear about when the disaster response should be brought to a conclusion and mainstream services pick up the task of responding to future trauma related needs

In more detail planning for disaster mental health should:

1. Be an essential part of political and administrative plans for the response to disasters and catastrophic events
2. Provide for a continuum of care to include
   a. Public education
   b. Location specific services (school, work etc.)
   c. Specialised services
3. Be grounded in the available evidence base on:
   a. The impact of traumatic events on the mental health of adults and children, and on
   b. Effective treatments and interventions for trauma related disorders
4. Be capable of being implemented, mindful of local pre-disaster realties and the conditions post-disaster which will only become apparent after the disaster or catastrophic event(s) has occurred
5. Be capable of adapting to the fluid nature of *community* in the wake of major disasters or catastrophes
6. Be sensitive to local practical and cultural circumstances including those features which may be associated with the perceived cause of the disaster (particularly relevant in terrorist caused disasters)
7. Support joint planning and training
8. Include a commitment to on-going evaluation of need and service impact.
9. Inform service development, commissioning and funding plans

10. Be capable of scheduling service responses in the period after a disaster and of bringing the disaster response to an end, when local mainstream services are capable of addressing any on-going and emerging needs and disorders.

Participants discussed these matters at some length and the following summaries the key principles and qualities required in preparing a Disaster Mental Health Strategy and associated plans.

- Where the scale and risk of a disaster threatens the existence and functioning of communities, it is important to see COMMUNITY continuity with the same degree of importance and imagination as BUSINESS continuity.
- Mental health services should not operate in isolation but their efforts should be integrated into the wider disaster response and the task of re-establishing and developing communities.
- Commissioning of services should be grounded in the evidence base about trauma related needs and effective trauma focussed services.
- Mental health services should be led by people who will ideally be competent mental health practitioners AND have experience, or knowledge and skills, in the management of the mental health response to disasters.
- The development and coordination of services should ideally be led by staff who are trained in evidence-based trauma focussed models. Otherwise managers should have recourse to people capable of delivering evidence-based trauma focussed advice ad support.
- We need to think in terms of 'disaster mental health' where services are placed on an appropriate footing to address the needs arising from a disaster. As already noted, conventional service arrangements will not be sufficient in responding to a disaster or unfolding tragic events (such as civil conflict or war)
- Services need to evolve, develop and change to reflect the unfolding needs through the acute, medium and long term phases; psychological first aid is appropriate to the early stages; thereafter services need to be in place and if not in place, developed, to address the longer term, chronic and clinically more challenging needs.
- Strategies and plans should take account of the circumstances in which a disaster has arisen especially where there is perceived to be a human cause, including terrorism, mindful of matters to do with trust and confidence, fear etc.
- The needs of children and adolescents, and the needs and role of schools and childcare services need to be specifically addressed.
- The needs of other specific vulnerable groups who are adversely affected or caught up in events should be the subject of active consideration
- Strategies and plans for mental health responses should take account of unexpected consequences of disasters for mental

health and service design and delivery, such as the loss of major utilities.

- At planning and post disaster stages agreements should be reached as to which providers will provide what services. Coordination is required to avoid a free-for-all and to ensure that services are providing a response which is: -
  - Coordinated with the efforts of others
  - Evidence based
  - Complying with approved standards
  - Appropriately scheduled
  - In accord with the locally determined strategy for responding to the disaster
  - Properly funded
  - Supporting a meaningful commitment to evaluation
- Plans should address resource and logistical matters. At higher planning and commissioning levels planning should provide a framework as to the characteristics of services thereby informing what resource and logistical arrangements need to be put in place.
- Plans should include provisions for the incorporation and support of informal, neighbourly and lay contributions.
- Lay workers should be appropriately recruited, trained and supported in accord with the evidence base and the objectives of the Disaster Mental Health Strategy. The importance of the contribution of first responders and lay workers was stressed – an emphasis which should have consequences for their training, mobilisation and support.
- Staff accreditation is often a concern particularly during the initial disaster response phase. This is a matter for disaster planners and accrediting bodies. Organisations should have arrangements in place to ensure that staff (profession or lay) are suitably approved for practice, if necessary, through initial interim provisions. Cross-border issues will need to be addressed here also.
- Funding for disaster mental health services should be linked to the Disaster Mental Health Strategy which should be informed by the evidence base on psychological care of people with trauma related needs and disorders.
- Funding for organisations should be contingent upon those organisations being committed to:
  - The disaster mental health strategy
  - The evidence base on psychological care
  - Compliance with approved standards
  - Evaluation and
  - Where relevant to appropriate accreditation of staff and volunteers.
- Where appropriate, health insurance organisations should be included in the planning and response to ensure that they understand and are supporting the objectives of the disaster response.

- We need to bridge the gap between researchers on one hand and planners, commissioners, trainers, providers and practitioner on the other. There is a pressing need to translate the research into key, understandable, digestible messages and for these messages to inform and shape policy and action. (The UK NICE guidance on the management of PTSD in adults and children was seen as a starting point).

4.0 Providing evidence based services

As noted previously, almost certainly, conventional pre-disaster arrangements for mental health services will not be appropriate or sufficient to address the circumstances of disasters (unless disasters are sufficiently common to justify the resourcing of ready-to-go services). A major disaster or catastrophe will give rise to, or arise from circumstances of high need and insufficient resources (see Chart 1).

The ability of existing services to respond to disasters will depend on the availability of (and therefore access to) services, and the degree to which the mental health services are attuned to trauma related needs.

Clearly then it is important that disaster plans for local communities include and integrate with other aspects of the overall plan, a mental health plan with the key mental health services and personnel involved at the earliest planning stages. To be most effective and to ensure energies are directed most effectively, plans and services need to be supported by clear evidence based conceptualisations of how people are affected by traumatic events and how best to assist them[2]. As well as informing the practice of mental health professionals, the evidence base can be used in promoting, legitimising and encouraging positive responses and initiatives (i.e. those more likely to promote resilience, coping and recovery).

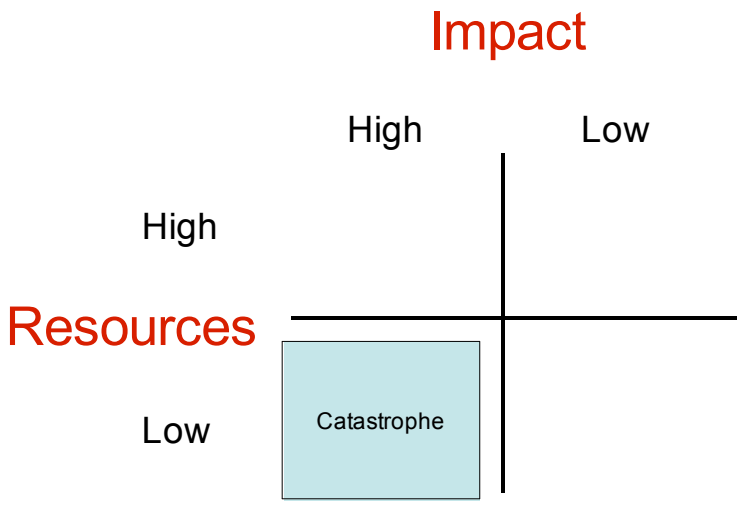

Chart 1: Matrix of Impact over and against resources to locate the context for a catastrophic or major disastrous event

[2] See Guidance issued by the UK National Institute for Clinical Excellence (NICE; 2005) on the management of PTSD in adults and children; http://www.nice.org.uk/248114

Related to this is the very important question of whether local or incoming services have the capacity in terms of numbers of staff or the skills and knowledge base to provide a service. Workshop participants believed that in both the UK and the USA currently there would not be sufficient mental health practitioners and others, using evidence-based trauma focussed interventions to provide an adequate response in the wake of a major catastrophic disaster. The question remains in the context of preparing for disasters, as to what is the most efficient method for disseminating evidence based treatments on a large enough scale to have a public health impact. Important ethical and practical issues are therefore raised on how to approach the challenge of not having sufficient or competent services to respond to need. How best should services respond whilst adhering to the evidence base?

The Workshop concluded that further development in capacity and competence is required in relation to trauma related needs and services if communities are to be sufficiently ready and resourced (i.e. in terms of skills and knowledge) to provide a robust mental health response. Additionally, in circumstances of overwhelming need and demands it will probably be necessary to do one or more of the following, within a framework of the evidence base:

- Shift the focus of existing services from clinic based provision to an increased focus on psycho-education and support for front line services.
- Deploy available skilled staff to targeted need and to support the psycho-educational effort
- Bolster local services by bringing in additional external services to assist, or in dire circumstances to lead and deliver the response.
- Mobilise and equip people in the community to take on roles that would previously have been the task of identified practitioners whose contribution for one reason of another have been lost to the community or is otherwise insufficient to address the need.

4.1 The Focus of Disaster Mental Health Services

The delivery of the strategy underpinned by the conceptualisation previously referred to (as to how people are affected by traumatic events and how best to assist them) needs to be sensitive to and realistic about the organisational and operational issues. In a context of overwhelming need and demand for services, where resources are stretched decisions will be required as to what can and ought to be done. It will be necessary to shift focus, particularly in the short to medium term, to those things which:

- Promote coping and resilience
- Prevent deterioration or onset of illness
- Promote recovery and adjustment
- Reduce the demand on existing services

- ⊕ Maintain ordinary services to people with non-disaster related needs that predate the disaster or arise thereafter
- ⊕ Promote the ability of families etc. to identify need and support individuals
- ⊕ Promote help seeking as early a possible where needs are not settling down

So, disasters will require a re-focussing of mental health services (with implications for planners, commissioners, providers and trainers). In the pre-disaster context, services will have developed on a planned and incremental basis in response to the priorities of the community and its government. Following a disaster, the energies and contribution of specialists in trauma and disaster mental health are better deployed, particularly in the short to medium term, in leading or supporting the leadership of disaster mental health responses and in preventing the onset of illness and in supporting recovery (including effective early interventions and treatments).

Whilst endeavouring to maintain mainstream (i.e. pre-disaster) services, the disaster response will require a shift towards supporting primary and secondary care, with a significant increase in health promoting through public education, early detection and intervention initiatives, focussing where it seems appropriate on high risk groups. The balance amongst the mental health components in the community affected by the disaster will depend upon the pre-existing profile of services and the scale and nature of the consequences of the disaster. In summary, the disaster configuration should see a reduction in the clinical work of specialist services with a reorientation to training and support for other services and initiatives, support for policy makers, and for service and community leadership. Likewise secondary care services should refocus to address the immediate and unfolding need. Primary care services are likely to face significant initial and on-going demands and will need support, the nature of which should evolve over time, from secondary and specialist services. Public education initiatives should expand to provide reassurance, support coping and to promote and guide help seeking.

As noted already, disasters will require the mobilisation of lay people (i.e. people who might or might not have a relevant service or professional background, but in nay case whose previous work or life experiences have not equipped them to undertake post disaster roles, or whose jobs would not necessarily have required them to undertake such roles). The key tasks for supporting a community affected by disaster, and therefore for mobilised lay persons are to educate and inform the population, to reassure and to promote help seeking if symptoms emerge or persist. We need to think through how they should be trained and to what levels and in relation to what content. They need to be supported and importantly, supervised.

4.2 Promoting Resilience

The Workshop discussed what was meant by resilience separating out personal psychological resilience, from the resilience of a group or community. One of the targets for intervention is to bolster inherent capacities for, and expectations of, coping effectively. Participants concluded that, in psychological matters, the challenge is to have an expectation of coping and adjustment of members of the community whilst being ready to intervene. We noted too, that personal resilience factors would not necessarily prevent the onset of trauma related disorders. At a community level, in the face of immense need or concern, the challenge is to avoid undermining community self-sufficiency and coping by intervening too much, whilst again being ready to intervene. Participants heard that the nature of the interaction required to work with others, as professionals, in the area of resilience building, is based more upon a gift relationship rather than the provider-recipient relationship.

The Workshop identified the following as the key objectives of promoting resilience.

- To optimise self sufficiency and effective coping
- To support the emergence or maintenance of a 'realistic optimism'
- To minimise mental ill health
- To improve help seeking

The Workshop concluded that there would be merit in further exploration of resilience building that is in sympathy with the direct and indirect promoting and optimising of mental health and well being in the face of the real circumstances facing a post disaster population. Mindful of the interplay between psychological and other factors, it was recognised that a further consideration of psychological and community resilience should incorporate considerations from social anthropological analyses with a social, economic, civic and health focus.

4.3 Children and Young people

The Workshop's attention was drawn to the needs of children and young people on a number of occasions. (The needs of other groups were also noted, such as older people, people with pre-existing mental health disorders and learning disabilities).

It was noted that the pre-trauma emotional state, the anatomy and biology of children and adolescents and the range of reactions are substantially different from adults. The needs of children and adolescents need to be viewed within the social context they inhabit (e.g. how the presence and reactions of adults impacts on their view of what is happening, of their own feelings etc.) and of their social and personal capability of stating their needs and seeking help.

Whilst knowledge about how best to help young people has gained considerable ground in recent years, much remains to be learned, especially about the needs etc. of those under 8 years of age.

The role of the education system was considered to be an important component in supporting children and adolescents and some good examples of progressive practice were noted.

In terms of treatment, the Workshop heard about the need to listen to children and to follow their description and explanation of the personal impact of and reaction to traumatic events.

Treatments for PTSD in children have developed with preferred treatments being identified in the NICE Guidelines (op. cit.).

4.4 The Media

It was clearly recognised that in a post disaster context the media have a key role in informing and orientating a community's perception and knowledge about what is happening, about what the risks are and for communicating advice and information on how best individuals and communities should respond. In the immediate aftermath of major disasters there is a need for and sometimes an absence of a sufficient narrative of what is going on. People at the heart of the tragedy seldom can see the whole picture, and therefore cannot orientate their efforts in pursuit of a wider common set of objectives. Particularly in the early phases after a disaster the media have a key role to play in providing this narrative.

The task of imparting information on these factors to communities is a very special area in judgement and balance. As one of the participants, Michael Labate, put it:

"Media are part of the disaster space, an unavoidable, inevitable, potentially valuable and necessary part, and their role as the 4th estate is to question and explore and might alter the shape of the 'disaster space'."

Another participant, Mark Brayne encouraged the Workshop to "*Plan so that the media are part of the solution – not seen as a problem*".

4.5 How long are Disaster Mental Health Services needed for?

As the community adjusts to and recovers from the traumatic consequences of the disaster, services can be returned to something approaching pre-disaster status, with a number of qualifications. First, the number of those

with psychological and mental health needs is likely to be significantly reduced but capacity should remain in place to address late onset and late help seeking. Second, the reconfiguration of services after a disaster should incorporate service developments from the post-disaster experience, to be available for people affected by other traumatic experiences, and to improve readiness for addressing further tragedies. Third, for a variety of reasons, pressures can develop to reduce mental health disaster services before they should be reduced or to prolong them longer than is necessary. Careful and evidence based calibration of this process is necessary to ensure that services remain in place for as long as is necessary.

4.6 What needs and what services?

It is important that in responding to a disaster an understanding of the unfolding nature of mental health needs is incorporated into response plans and service provision. It can be expected that, in the early weeks following an acute disaster, or over time in an unfolding situation that, a large number of people will present with varying levels of distress. Thereafter the presentation of need settles down, responding somewhat but with decreasing amplitude to events (such as anniversaries). An example of the demand for psychological services over time is given below. The needs in the early acute phase of largely acute distress can by and large be adequately addressed through informed front line and primary care services (receiving support from secondary and specialist services). Here, the wider community also have a part to play in providing reassurance and connection to that community. Efforts to ameliorate pre-existing and consequential hardships and life problems such a financial difficulties, housing etc., will also assist psychologically. Where indicated, people with overwhelming trauma related needs should be referred for secondary and specialist services in this phase.

During this phase NICE recommends[3] 'watchful waiting' i.e. providing initial support (mainly psycho-education) and monitoring of adults or children who present with initial problems in the expectation that initial distress will resolve and no long term problems will ensue, but ready to refer for appropriate services when indicated. Thus if symptoms develop and persist then treatment for PTSD or other trauma related disorders should be offered using a trauma focussed (evidence based) treatment. NICE advises that Critical Incidence Stress Debriefing (CISD) should not be used routinely with individuals. Also, drugs should not be used as a front line response.

Relevant services should be equipping themselves during this phase to provide evidence-based responses to trauma related disorders (again NICE).

[3] op. cit. UK National Institute for Clinical Excellence (NICE; 2005) on the management of PTSD in adults and children; http://www.nice.org.uk/248114

The experience of the Omagh Community Trauma & Recovery Team gives an indication of the profile of demand over time. This team provided an open access service for the public (also taking referrals from services) and was the widely recognised principal point of entry for support for people affected by the bombing. The Chart shows a very significant demand in the first three to four months followed by a significant reduction to much lower levels. Early referrals were characterised by heightened levels of distress and worry over symptoms and the failure to recover. Later referrals were characterised much more by increasing complexity of illness, especially in relation to adults referred to the team. The former group of referrals required reassurance, information, support and some primary or secondary care interventions. The latter was subsequently shown to need evidence-based trauma focussed interventions and other supporting therapeutic services[4]. In the group of patients reviewed in the Omagh audit of treatment using a trauma-focussed treatment for PTSD it did not seem to make a difference to treatment outcomes when people presented for treatment after the bombing[vi].

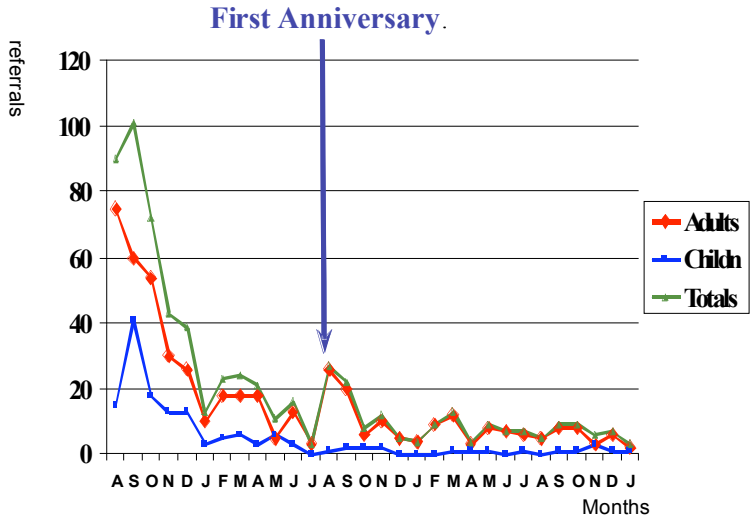

Chart 2: An example of unfolding demand; the pattern of referrals to the Omagh Community Trauma & Recovery Team 1998-2000

In the face of overwhelming or potentially overwhelming demands and needs, how best can services respond? One possible action is to undertake a pre-emptive initiative, which reaches out to people pro-actively, before they develop problems or before they feel they need services. Humanitarian and resource arguments have been made in support of this approach. An alternative view is that it is better to monitor and respond where indicated, and that during this period services should be gearing up for the delivery of trauma

[4] At the time of publication almost 10 years after the bombing referrals are still being received by local services in respect of patients with trauma related mental health needs associated with their experiences of the bombing

focussed evidence based interventions targeted at those who come forward or are referred with trauma related needs and disorders.
At one level the proactive approach can be supported where for example widespread initiatives can be used through the media and leafleting to communicate very important and simple messages to citizens. Going further by offering blanket services and assessments remains open to question on the grounds of cost effectiveness (see section 2.3.4 also). Also, unless proactive offers of services or assessments are repeated, people who develop late onset trauma related disorders will be missed.

Proactivity might be important to consider where there are distinctive groups, which by merit of pre-existing circumstances or features of the disaster mean they are seen to be, or deemed to be clearly at greater risk of developing problems. Again, there is a trade off to be considered between focussing energies and attention on some groups of citizens over and against the task of gearing up a wide range of services to be attentive and responsive to needs as they emerge.

One option is to undertake a needs assessment study, which investigates the pattern of need in a population or groups. This can be beneficial in distinguishing features of the disaster, which are likely to have significant implications for psychological trauma care (and other areas of need and service). This information can then be used to assist in developing strategy and in the design and resourcing of services.

In summary, proactivity, and monitoring and responding need not be mutually exclusive. A proactive approach with a public education focus, can then be followed by appropriate targeted monitoring and response. Attention should be paid to the need to use resources wisely, to target where this is indicated and to take time to develop services where this is needed.

The Workshop discussed the issue of routine or blanket debriefing of civilian populations. The debate in this matter, especially in the manner in which CISD (Critical Incident Stress Debriefing) or CISM (Critical Incident Stress Management) was covered in the discussions. There was some concern expressed about protocol driven responses at this immediate post impact stage and note was made of the recommendations from the NICE report (op. cit) that CISD should not be used routinely with individuals in post trauma situations. It was also noted that ‘doing nothing’ was an inadequate response. Psycho-education, with watchful waiting and some targeted assessment and interventions where appropriate, backed up by the promotion of a culture of help seeking and improved access to evidence based services, were considered to be key components of an appropriate mental health response, in the immediate wake of a disaster. The importance of planners, commissioners and services being attuned to the impact on and needs of children and young people, and those with special needs, was also emphasised.

4.7 Specific service considerations

As previously stated on a number of occasions, services will be more effective if designed with the evidence base about risks and interventions in mind. For example, regarding PTSD factors known to influence the risk of developing the condition include:

- Factors associated with the traumatic experience(s)
- Personal characteristics (such as genetic factors, being female, previous emotional problems)
- Psychological responses during the traumatic experience including the perceived threat to oneself or others, degrees of helplessness, guilt, shame or dissociation[5]

Additionally, the way in which people cope with or psychologically manage their experience and their reactions is important in helping to identify those who might have or develop problems. Following the Oklahoma bombing North et al found that the avoidance clusters of trauma symptoms were very important. Clark found that intrusion symptoms predict well the development of PTSD[vii]. A study in New York after the attack on the World Trade centre in 2001 found that event experiences were predictive of PTSD[viii]. The Workshop heard that each sudden and unexpected death results in about 5 bereaved persons of whom 10-20% will develop complicated grief at 6 months or more. Using known risk factors, mental health and related responses can be developed targeted at those risks that can be ameliorated, such as social support (whereas socio-demographic factors cannot be readily changed or changed at all). The variation in the findings in the above studies is an important point to note, drawing attention to the need for further research in this area, and in planning and response terms to the need for vigilance as the knowledge about predictors of who will and will not develop PTSD (and other trauma related disorders) remain imprecise, although knowledge is building.

4.8 Providing a continuum of care

A specific set of suggestions and recommendations relating to services emerged from the Workshop, which are summarised below. As noted earlier mental health disaster plans for communities should provide for a continuum of care to address the needs arising at different stages following a disaster. (When these stages are reached will be a matter for consultation and judgment, and are contingent upon the nature of the disaster and its consequences). This continuum should include and be designed around

- Public education
- Locations specific services (school, work etc.)
- Specialised services

[5] Dissociation is a psychological defence mechanism in which specific, anxiety-provoking thoughts, emotions, or physical sensations are separated from the rest of the psyche.

Each of these should be designed around the evidence base and as noted earlier around what is achievable and acceptable with the disaster-affected community.

To assist workers (lay and mental health professionals) checklists of what needs might arise at each phase, along with a check-list of what we are trying to address at each of the above stages (e.g. lower distress, promote help seeking, reduce isolation, normalise) would be helpful in enabling guidance and treatment to be offered.

Children's needs should be planned and provided for and understood, explicitly, with awareness of the role of parents, other key adult figures and schools in the wellbeing and adjustment of children and young people.

To enable statutory, voluntary and private organisations to work together, clarity will be needed on the respective roles and responsibilities and at what point each should contribute.

Commissioning, informed by disaster mental health plan and the evidence base, was seen to be a key driver and determinant of services. Passive commissioning might deliver some effective services but if a community is to be assured of a competent response then commissioners have a vital part to play. Commissioners could ensure that, within resource constraints, there is a balanced portfolio of services located appropriately to deal with different phases and mental health needs.

4.9 Psychological First Aid

Some of the debate on this matter has been covered in previous paragraphs. There was general agreement in the Workshop that in the early stages communities should be supported through the provision of *psychological first aid* although the scale of a disaster could place limits on what can be delivered and achieved. Practically, it may be sufficient to direct such services at those deemed to be at greatest risk of developing psychological problems. It was noted on several occasions that NICE is recommending that CISD (Critical Incident Stress Debriefing) should not be used with individuals routinely[6]. Psychological first aid services are aimed at orientating the individual (who might or might not present with distress) in the most appropriate direction to aid their adjustment to and management of any current or future distress. There is additional potential benefit of equipping people involved in traumatic events to support others and to recognise when others need help. Such services should incorporate the following features:

[6] There is, as noted earlier, an ongoing debate as to the contribution and effectiveness of CISD

- Active listening
- Reassurance through normalisation
- Provision of appropriate and supportive advice and information to include self care and self monitoring
- Helping people to identify problems they cannot handle
- Modelling helpful reactions to traumatic stress
- Advice and guidance on maintaining a lifestyle favourable to mental health and wellbeing
- Providing information on how and when to refer themselves
- Specific attention to the needs of children, young people and other specific groups
- Helping people understand the needs and reactions of others and how they can support others

Psychological first aid service practitioners should be able to refer to other more specialist or supportive services where indicated. They should not normally engage in any therapeutic steps beyond that described above.

Staff providing psychological first aid should be supported

- Through supervision; including how best to use supervision
- In considering and addressing ethical matters
- In the evaluation of risk (including suicide risk).

It will be important that community leaders, including politicians, and senior and middle managers within relevant organisations understand the value, purposes and process of delivering psychological first aid to a disaster affected community. Briefings on this and other related matters should be provided for these groups, ideally in advance of a disaster and certainly in the immediate period following. It is highly desirable that such information cascades through organisations and community structures, so that there is an understanding of the task being undertaken by services providing the initial mental health response and to mobilise supportive responses by lay people in response to the situation they find themselves in. A broad goal here is to enable and generate a conversation with the community that deals with the emotional and personal impacts of traumatic experiences. In this regard the media and community leaders have valuable roles to play.

5.0 Appendix 1

List of Delegates

Alastair AGER	Professor of Clinical Population and Family Health, Columbia University
Penny BEVAN	Head of Emergency Preparedness, Department of Health
David BOLTON	Director, Northern Ireland Centre for Trauma & Transformation
Mark BRAYNE	Director, Europe, Dart Centre for Journalism & Trauma
David CLARK	Head of the Psychology Department at the Institute of Psychiatry, King's College London; Director of the Centre for Anxiety Disorders & Trauma, Maudsley Hospital, London
Angela CURRIE	Head of Operations, Women's Royal Voluntary Service
Oscar DALY	Consultant Psychiatrist, Lagan Valley Hospital, Northern Ireland
C.J. DAVIS	Commander, Atlanta, Georgia Police Department, Office of Homeland Security
Patrick DEENY	Senior Lecturer in the School of Nursing, University of Ulster
Joanne DIFEDE	Director, Program for Anxiety and Traumatic Stress Studies and Associate Professor in the Department of Psychiatry, Weill Cornell Medical College (New York)
Barry DYER	Senior Physician, International SOS
Julia FOGARTY	Emergency Planning College
Mick FREE	Chief Inspector, National Emergency Procedures Unit, Metropolitan Police
Mary GILBERT	Consular Directorate, Foreign and Commonwealth Office
David GOULDING	Health Emergency Planning Advisor, Welsh Assembly Government
Peter GUDAITIS	Executive Director & CEO, New York Disaster Interfaith Services
Eugene HAGAN	Emergency Response Manager, Homefirst Community Trust, Northern Ireland
James HALPERN	Professor of Psychology & Director of the Institute for Disaster Mental Health at the State University of New York at New Paltz
Margaret HANNAH	Public Health Consultant, NHS Scotland
Jack HERRMANN	Assistant Professor of Psychiatry, University of Rochester (New York) Medical Center; Director, Program in Disaster Mental health, Center for Disaster Medicine and Emergency Preparedness, University of Rochester Medical Center
Gerard JACOBS	Director of Disaster Mental Health Institute and Professor in the Clinical Psychology Training Programme, the University of South Dakota
Michael LABATE	Director of Emergency Preparedness and Disaster Response, New York State Office of Mental Health
Randall MARSHALL	Director of Trauma Studies & Services, New York State Psychiatric Institute; Associate Professor Clinical Psychiatry, Columbia University College of Physicians and Surgeons; Co-Director, Center for the Study of Trauma and Resilience, Columbia University and the New York State Psychiatric Institute
Muriel McCLENAHAN	London Resilience Team
Duncan McGARRY	National Police Family Liaison Advisor
Ian McPHERSON	Senior Policy Advisor, Department of Health; Director, National Institute of Mental Health
Janet MEACHAM	Department of Health (UK)
Rosie MURRAY	Human Aspects Consultant, Awareness Raising for Trauma

Neil ROBERTS	Consultant Clinical Psychologist, Cardiff Traumatic Stress Service
Suzanna ROSE	Project Leader, Berkshire Traumatic Stress Service, Berkshire Healthcare NHS Trust
James RUBIN	Research Fellow, Institute of Psychiatry, King's College London
Monica SCHOCH-SPANA	Senior Associate, Center for Biosecurity and Assistant Professor Medicine, University of Pittsburgh
Richard SHADICK	Director of the Counselling Center, Pace University (New York)
Leslie SLOCUM	British Consulate-General, New York
C. EDGAR SPENCER	Director, Disaster Response, Department of Mental health, State of South Carolina
Roy TAYLOR	Director of Community Services -- Royal Borough of Kingston upon Thames
Carol ULMER	Manager, Acute Services Unit, Philadelphia (Pennsylvania) Office of Behavioral Health and Mental Retardation Services
Lillian VALENTI	Chief of the Office of Medical Services, Port Authority of New York & New Jersey
Moya WOOD-HEALTH	Emergency Planning/Civil Protection Adviser, British Red Cross Society
William YULE	Professor of Applied Child Psychology, Institute of Psychiatry, King's College London

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